KENTUCKY BOARD OF OPTOMETRIC EXAMINERS

163 West Short Street
Suite 550
Lexington, KY 40507
(859) 246-2744
http://optometry.ky.gov

APPLICATION TO UTILIZE EXPANDED THERAPEUTIC LASER PROCEDURE(S)

Name _____

Address _____

Kentucky Optometry License Number _____

Name of course that qualified you for credential to perform expanded therapeutic procedures (verification must be sent directly from school to Board): _____

Place and date of course completion: _____
What is the name and address of the preceptor who witnessed the anterior segment laser procedure(s) you are seeking a credential for? _____
_____

What procedure(s) are you seeking a credential for? □ ALT □ SLT □ LPI □ Capsulotomy
Where and when was the procedure(s) performed? _____

_____ _____
Applicant's Name (please print) Date

_____
Applicant's Signature

Date Printed: August 2011